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ASHA

Journal of the American Speech and Hearing Association

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CONTENTS

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Asha

APPLICATIONS FOR MEMBERSHIP SHOULD BE ADDRESSED TO THE EXECUTIVE SECRETARY

SOME PROBLEMS OF RELATIONSHIPS BETWEEN SPEECH AND HEARING SPECIALISTS AND THOSE IN THE MEDICAL PROFESSION

HEROLD S. LILLYWHITE AND RICHARD L. SLEETER*
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In a young, vigorous, rapidly growing profession, such as that of speech and hearing, problems of relationships with other professions necessarily will occur. Among the most critical and troublesome are problems of relationships with persons in the medical profession. Some of the consequences of these problems may be listed as follows: 1) Misunderstanding, suspicion, lack of confidence of each specialist for the other often are present; 2) Parents and patients sometimes are misevaluated, misinformed, confused, and mistreated; 3) Too many physicians make speech evaluations and offer remedies for speech problems; 4) Too many speech and hearing specialists make medical and psychiatric diagnoses, offer remedies, and make recommendations that are within the realm of medicine.

ORIGIN OF PROBLEMS

In order to understand these problems, it is necessary to examine some of the reasons for them. One reason is that medicine is a much older, more stable and, perhaps, revered and feared profession than that of speech and hearing; consequently, it is not easy for the most constructive kind of intercommunication and professional relationships to be established and maintained between individuals in the medical profession and those in the relatively unknown profession of speech and hearing. Another reason certainly must lie in the nature of medical education. One young physician recently commented, after he had witnessed a speech examination of his own son, that one of the most serious omissions from his medical education was the opportunity to gain an adequate understanding of speech and hearing problems. The physician too often thinks of speech as being confined to the organs of articulation—and of the speech specialist as being concerned only with the manipulation of these organs. The medical student, and very often the physician in practice, has had little or no opportunity to learn about speech and hearing problems or the speech or hearing specialist, what he can do, the nature of his training, where he can be found, and how to communicate with him.

It is true, also, that the physician often has found it necessary to assume the position of final authority in dealing with a wide variety of problems of patients that come to him. For the most part he must make examinations by himself, depend on his own resources, come up with the "answers," and offer remedies. The lay person has come to expect this of the physician; that is why frequently he is the first person approached by parents of a child with a speech problem —and he often is held to be less than competent if he cannot "cure the ailment." He is asked to diagnose, offer counsel, and sometimes even therapy for a speech problem just as he would for a case of pneumonia. The physician himself is not to be blamed for being put into this kind of a position, but the situation should be understood. It is largely the nonmedical people who have put "The Doctor" on a pedestal that he does not necessarily seek for himself. He has been made a "final authority," a professional person above all other persons, and often one who is not to be questioned. It is only human that many would accept this role.

The nature of the training in speech and hearing also leads to many problems in relationships with the physician. The most serious aspect of this seems to be the fact that training for the profession of speech and hearing has developed in a nonmedical educational setting, often in a college of liberal arts; and perhaps far out of context with health and medical aspects of persons with speech and hearing problems. It is rare that the training in speech and hearing offers adequate opportunity for an understanding of the role of the family physician, the pediatrician, or other medical specialists in the over-all concern and care for a patient who also has a speech or hearing problem. The result is that the speech or hearing specialist tends to assume too much responsibility when he undertakes diagnosis and therapy for an individual. He tends to function in isolation, especially from the physician

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and his over-all care of the child. He fails to make use of medical help that is available.

Because the profession of speech and hearing is young and relatively insecure, and because it covers such an extremely wide range of kinds of training and functions, the speech or hearing specialist often lacks the stability, security, and confidence that he needs in approaching the medical specialist as one well-trained, independent specialist to another. He tends to take a subordinate role upon himself. In other cases this same insecurity causes him to raise unnecessary defenses, suspicions, and often to complain that his work is not understood and appreciated by the physician.

We need also to consider the attitudes of parents and patients toward both the medical and the speech and hearing specialist. It is entirely normal for a parent of a child with a speech or hearing problem, or an adult with such a problem, to go to the physician first for help. It is equally normal for them frequently to accept the doctor's word as final. If those in the medical profession are uninformed about the existence of a speech or hearing specialist, it is even more true of those not in the medical profession. The lay person often has never heard of a speech pathologist, speech therapist, or audiologist. If he has, he probably has a most distorted concept of what they do.

Other lay individuals, at times, will know about a speech or hearing specialist, but may create misunderstanding between this specialist and the family physician. It is not uncommon to have parents give false and misleading information to one specialist about what the other has told them. It also is true that persons will go from one specialist to another seeking the answer they want to hear, rather than factual information. If the specialist relies entirely on the information about what another specialist said or did, as it is reported to him by the individual with a problem, he may well be misled. For this reason it is tremendously important that the speech or hearing specialist have the lines of communication well open to those in the medical profession.

One final aspect of the cause of poor relationships is the belief of some of the medical specialty groups, and a few individual physicians, that the speech and hearing specialist should be an ancillary or submedical technician working only on orders from a physician. The medical person who thinks this way, of course, is the one who sees nothing inconsistent in his diagnosing speech and hearing problems and prescribing treatment in spite of the fact that he may have had no training whatever for this task. One particular branch of medicine has taken steps to incorporate the speech and hearing profession as a submedical group of this kind.

This development may have been fostered partly by the willingness of some in speech and hearing to take subordinate roles, and partly by improperly trained persons being put in positions where they are incapable of demonstrating the necessary competence. If a speech pathologist or audiologist is to function on an equal basis in a medical diagnostic setting, for example, he must be entirely competent in his specialty; or he soon loses his status of equal. Yet a great many young therapists – persons with a minimum of training and experience and often no clinical certification – have been willing to take positions in situations of this kind; then have been relegated to the role of "therapist" in its most limited sense, and have accepted and fostered the idea that they should function only on prescription from the physician.

POSSIBLE SOLUTIONS

If these are some of the problems and their causes, what then are some of the solutions? Probably the most evident long-range solution lies in the development of more maturity, more stability, and more widely recognized professional "status" of the speech and hearing profession. This will take time, but the time can be shortened by working at it.

There are some steps that can be taken immediately to bring about this long-range solution, and some immediate betterment of relations with the medical profession. There is need, first, to begin by a change in attitude on the part of those in speech and hearing toward themselves and toward those in the medical profession. The physician needs to be taken off the pedestal he has been put on. He is human and fallible, and has not asked for the position of final authority that has been given him. He needs competent help, and greatly appreciates it when he can get what he needs. Granted, he often must be shown the kind of help that he needs and the kind of help that can be given; but this cannot be done by continuing to erect barriers between the two professions.

One of the quickest ways to get the physician off his pedestal, and to break down barriers, is to involve him in evaluations and therapy of children with speech and hearing problems. Because the speech and hearing specialist has been trained and, by necessity, has worked in situations where it is expedient to "go it alone" in diagnosis and therapy, many other things

that are happening to the total child often are missed. Probably the majority of children or adults with speech problems should never be seen by the speech or hearing specialist without the latter first having had either a talk with the individual's physician or a written report of the medical aspects. This is not always easy to accomplish. In those instances where medical information is called for, it is not enough just to ask the physician or his secretary, by note or telephone, for a "report." The physician has little notion of the kinds of information that will be useful. He needs to be told what is needed.

The writers have had the experience of trying many different methods of getting this information from physicians and have finally settled upon the method of writing the parents a letter, at the time they make a request for an evaluation, indicating that an appointment will be given as soon as we have the necessary medical information. We indicate in the letter the kinds of information we need from the physician in somewhat the following manner: ". . . Our experience has shown that serious speech and language problems often are found to have an organic cause. Many times the cause isn't present when we see the child, as it may have resulted from earlier developmental problems, illness, or injury. For this reason it is important that we know something of a child's development, any serious illnesses or injuries, any problems that were present at birth, or events before birth that might have a bearing on the possible speech and language problem. Your physician often will have other information that he feels is significant for an evaluation. We feel it is important, too, that your family physician know of this evaluation so that we can share with him the information from our examination of your child. He may be in a position to give you considerable help. He will understand that speech and language problems often are closely related to medical problems, and that proper evaluation and treatment can be done only with the cooperation of the physician who knows the child best. We would appreciate it if you would call your physician and give him permission to release whatever information he feels might be significant to us . . ."

This letter is written personally for each referral made to the Clinic. A copy of it always goes to the family physician and specialists listed on the application form. Often it is followed up with a telephone call. This combination of requests from both our Clinic and the parents has produced excellent response and increasingly valuable information. If there is no family physician, nor a specialist who can give adequate information, we generally have asked that a medical examination be made before we see the child for speech evaluation. If this is impossible, or obviously unnecessary, we will see the child anyway; but this is the exception. All of this, of course, means that we must have an adequate application before we decide whether or not we should see the child. The application should tell us enough so that we know what kinds of additional information we need.

It has been most gratifying to see the continuing interest of physicians in speech cases when they have been involved in this manner from the beginning. Most of the replies are thoughtful and helpful. Even the occasional brief note, sometimes written in one sentence on a prescription blank, saying there is no medical problem related to the speech or hearing difficulty, is useful to us. Even if there is no useful information in the replies, a channel of communication has been opened and with it an opportunity to inform the physician about the profession of speech and hearing is then available.

Since the physician has been involved at the time of referral, the way to keep him involved is to give him an informative and useful report of the findings of the examination. This carries responsibility for an adequate examination, for a carefully written report, and extreme care in making recommendations. If the report reflects careful study and good judgment in recommendations, the physician — almost without exception — is very appreciative, and another step has been taken toward enabling him further to understand the functions of the speech and hearing specialist. It is at this point that a telephone call to the physician may be productive; especially if there is a problem that the speech specialist can discuss with him, and medical information which he might request specifically with respect to further study or therapy. This contact should be made as one independent specialist to another; not in the sense of asking the physician what to do concerning the speech problem.

Another way to keep the physician involved is to keep him informed of therapy progress, if therapy is undertaken, or of further diagnostic examinations, if this is the course. It is good also to have involved the parents in these exchanges as often as seems expedient. It is most helpful to have a mother, when she goes to her family physician, talk to him in favorable terms about the treatment her child has received at the hands of the speech or hearing specialist. Care must be exercised so that information is accurately reported by the parents; but if it is, it can be most helpful.

All of this kind of direct communication with the family physician is much easier, of course, in a clinic

situation than it is in the public school. But even the public school therapist, working alone or in a large system, can proceed much further in this direction than generally has been done. This has been demonstrated in a number of situations. In a large school system where there are many therapists, the contact with the physician should be channeled through the speech supervisor or consultant. This generally has been found to be much more satisfactory than when such contact has to be made through the public health nurse, the school social worker, psychologist, or school principal. None of these specialists is competent to interpret adequately the information related to a speech or hearing problem. The point is that the attempt should be made – the fact that contact may be difficult to establish is only a problem to be solved, not an insurmountable barrier.

It was previously suggested that too frequently the physician may be inclined to make speech evaluations and offer remedies where he is not qualified to do so. It is equally true that the reverse can be said of many speech and hearing specialists. With a "smattering" of information in the fields of medicine, psychology, and social problems it is most tempting to those in the fields of speech and hearing to begin to use medical and psychological terms; and finally, to begin to "sound like" the physician, the psychiatrist, or the psychologist in discussing speech and hearing problems with parents and others.

It is appalling to see an inexperienced or incompetent speech therapist make a quick judgment of a child and his family after a very brief examination and interview; and then proceed to describe the problem in a learned manner in terms that have been borrowed from medicine, psychiatry, psychology, and elsewhere. How easy it is for the speech specialist to get a quick picture of a family environment, that does not fit his concept of what a family environment should be, and then jump to the conclusion that this is the sole cause of the speech problem. He then proceeds to act on this assumption, thus precluding further investigation. Even more dangerous, perhaps, is the glibness with which such terms as "brain damage," "mental retardation," "retarded motor development," "in-coordination," and etc. are used after only a brief examination of a child. Then perhaps the suggestion is made that the child ought to have a "neurological exam," a "pediatric exam," and in too many instances even a specific recommendation from the therapist for an "EEG," which has been described to the parents as a "brain wave examination." After this explanation the terrified parent, of course, is going to seek frantically for someone who will give the "brain wave examination" to her child whom she now regards as mentally deranged or worse.

This kind of talk is almost certain to get back to the family physician, or the medical specialist who has been caring for the child. He cannot help but be shocked by what he hears; especially when it is misinterpreted, as it often is, by parents. It takes years to build good relations, but it takes only one episode of this kind to destroy them. The physician is only too willing to have his suspicions of an inferior specialty borne out by this kind of irresponsible behavior. So, while the speech or hearing specialist needs medical information, and should know how to use it, he should know how to get it and use it in relation to the speech or hearing problem – and should confine his discussion of these problems to terminology in his own field, and to recommendations with respect to these specific problems.

When the work of the speech and hearing specialist brings him into direct relationship with medical specialists, he will need to watch carefully the things he says, and the things he does not say. When talking to the physician about a speech or hearing problem, an individual needs to know what he is talking about. This does not mean that he has to know all the answers, but he must have made a thorough enough investigation to substantiate what he is saying.

Those who work very closely and constantly with people in the medical profession have found that it is not necessary to try to impress anyone by using medical terminology. What is said can be worded in the simplest, most effective manner possible. It is, of course, necessary to use terminology peculiar to the field of speech and audiology. It is important, however, to realize that the physician does not know this terminology; often he is unfamiliar with what is meant by "primary" and "secondary" stuttering, an "articulation problem," "dyslalia," "delay," "voice problem," and especially "aphasia" and the many other terms related to this problem. Often the use of the term "brain damage" by the speech specialist is misunderstood by the physician. Likewise, a "psychological" or "emotional" problem may not mean the same thing to the physician as it does to the speech examiner. The physician is likely to think of the emotionally disturbed child as one needing psychiatric treatment, and he will take steps to get it. The speech examiner often means that there are emotional components in the speech problem that should be considered.

Another need is the willingness to admit that there may still be some doubt about this child's speech

problem. Immediate answers are not often necessary. It suggests much more maturity and confidence if one can say, "I don't know. I would like to study it further," than to make a guess from inadequate evidence. The physician knows how risky it is to proceed with treatment until he is as sure as he can be of the ailment. He will respect another professional person for proceeding in a similar manner, although he may not previously have realized that a speech or hearing problem may demand this kind of careful attention. The speech or hearing specialist is in an excellent position to teach him this concept. This can be done if the child's speech or hearing rehabilitation is made a joint enterprise rather than a one man show.

The speech and hearing specialist needs to take every opportunity to inform the physician about his profession, its standards, Code of Ethics, certification, and membership. This is not an easy task. The difficulty encountered in explaining the American Speech and Hearing Association's system of certification has long been recognized. It is logical for the physician to assume that membership in the American Speech and Hearing Association is also recognition of qualifications and competence in the field. He is accustomed to thinking of "specialty boards" in his own field, and the matter of "certification" perhaps suggests to him as broad a thing as being certified for classroom teaching; but probably does not suggest the meeting of specific minimum standards of training and competence in the specialties of speech or hearing. Furthermore, a physician generally thinks that training in speech and hearing is somewhat on a par with training for classroom teaching, or similar to that of the occupational and physical therapist. He needs to be informed of the nature and scope of training programs in speech and hearing.

The fact that the American Speech and Hearing Association has a Code of Ethics, and is making a serious attempt to police its own ranks, needs to be brought home to the professionally conscious M.D. He needs to be shown that the "advertising" speech specialist is as unethical as the advertising physician. He needs to know how to recognize the "quack" in speech and hearing as he does in medicine. The physician also needs to be informed how to get information with respect to referral – or with respect to checking the qualifications of a person or clinic to whom he might refer a speech or hearing problem. He needs to know of the National Office of the American Speech and Hearing Association, of the annual *Directory,* and how to read it to check certification; and of state public school certification systems. He needs to be taught to turn to college, university, and private speech and hearing clinics of established reputation when he has a patient with a serious speech or hearing problem. This informing the physician can be done partly through national and local speech and hearing organizations; but a much more complete and thorough job can be done by individuals in person to person contacts.

RESPONSIBILITY AND RECOGNITION

Finally, if speech and audiology is to be an independent, respected, mature profession it needs first to act like one. Relationships with many other professional groups are highly important, but no place are they as critical as with those in the medical profession. Speech and audiology can neither afford to be swallowed up by the medical profession, nor can it afford to lose the respect and support of that profession. This sets an extremely difficult task, but one which, if recognized and approached with confidence and energy, can surely be accomplished.

Special Reports

ELEVENTH CONGRESS OF THE INTERNATIONAL ASSOCIATION OF LOGOPEDICS AND PHONIATRICS

THE Eleventh Congress of the International Association of Logopedics and Phoniatrics was held at Church House in London from August 17 through August 22. Approximately 514 people from 31 countries were registered for the Congress. Of these, 88 were from the United States. It seemed at certain times that we were back home attending an American Speech and Hearing Association meeting. There was one major difference, however. Everyone looked and talked as if he had purchased his own corner of paradise. Discussions of stuttering and cleft palate were intermittently punctuated with scientific inquiry into such intriguing problems as comparative analyses of Parisian sidewalk cafes, Florentine museums, Mediterranian spas, and Danish crafts. The intellectual man was replaced by his emotional counterpart, and experts in general semantics were heard to exclaim, "Isn't this wonderful!"

As important as the formal parts of the program, were the social events so beautifully planned and executed by the host group, England. A large reception at the London County Council Building provided an opportunity for representatives from many parts of the world to come together for social and professional exchange. The result was a fascinating mixture of British custom and continental grace coupled with our own wonderment and desire to participate, if only briefly, in a cultural pattern different in some respects from our accustomed one. Other traditional English social functions—four o'clock tea, cheese and wine in an ancient garden, the grand ball, and the formal dinner—provided a sample of English life and warm hospitality. However, these enthusiastic extra-curricular activities were complimented by the comprehensive professional program offered.

The meetings were opened by the Chairman, Leopold Stein, who welcomed the group to London and brought greetings from the Queen. This was followed by a particularly insightful address by the National Minister of Health. He spoke knowledgeably on communication disorders, their significance, and the desirability of technical and professional exchange on an intermotional level. Although the sessions continued for 6 days, the large number of papers accepted for presentation made it necessary for two sections to run concurrently.

Both sections usually included papers in German, French, and English. Since simultaneous translation systems were not used, mono-linguists found themselves decidedly handicapped in understanding much that was said. Emphasis appeared to be given to the areas of voice and articulation disorders, language deficits, and cleft palate. Such problems as stuttering, hearing loss, and cerebral palsy were discussed less frequently.

Of the approximately 85 papers presented, 21 were given by people from the United States. All but two of the American contributors were members of the American Speech and Hearing Association. The names of program participants from the United States were:

Helen H. Beebe	Katrina de Hirsch
Mildred Berry	Jeanette Jansky
John Black	H. Von Leden
Frederich S. Brodnitz	Mary Longerich
Ruth Clark	Betty Jane McWilliams
Louis DiCarlo	Paul Moore
Sue Ernest	Paul Moses
Jon Eisenson	George H. Shames
John Fisher	J. C. Snidecor
Emil Froeschels	Max Steer
Lynwood Heaver	D. A. Weiss

Joseph Wepman

One of the over-all impressions of program content was the contrast between the European and the American approaches to observation, collection, analysis, and reporting of data. It appeared that the American researchers gave greater attention to large group research methodology whereas Europeans tended in the direction of single case studies and small group samples. This seemed to result in a second impression which was that statistics as a tool of research was probably more often used by Americans than by Europeans. These impressions left the writers with two basic questions:

Editor's Note: This Report was prepared by George H. Shames, Ph.D., and Betty Jane McWilliams, Ph.D. Dr. Shames is Associate Professor of Speech and Psychology and also Associate Director of the Speech Clinic at the University of Pittsburgh. Dr. Betty Jane McWilliams is Associate Professor of Speech at the University of Pittsburgh and also Director of the Speech Clinic at the Children's Hospital.

1. How are the types of research being conducted in various parts of the world influenced by professional training, philosophy and sophistication in the application of various research methodologies?
2. To what extent can scientific data be meaningfully exchanged in the absence of a common research language?

A third impression growing out of papers heard at these meetings dealt with differences in research emphasis. Whereas, in the United States, there is currently much interest in the development of basic methods for measuring various dimensions of speech, the European seems to address himself more often to problems of clinical management. The exchange of these two orientations among researchers seemed to be mutually stimulating and left one with the feeling that a blending of the American and European approaches should be attempted.

A fourth general impression grew out of the apparent interest of discussants in the possible applicability of research data on an international level. It appeared that in many countries of the world, future plans for research might well be contemplated which would take into account cross-cultural needs. This may suggest that we here in the United States should begin to think of developing the leadership necessary for this emerging phase of scientific endeavor in speech and hearing.

As we recall the many experiences of the Congress, certain vivid images remain . . . the warmth and friendliness of the English people who were our hosts, the fine spirit of sharing on a cultural and professional plane among the Congress participants, the thought-provoking discussions, the security gained from realizing something of the universality of clinical and research problems, and, last but far from least, the many little personal adventures that made us feel that we had shared for a time in English life.

REPORT OF AMERICAN PSYCHOLOGICAL ASSOCIATION MIAMI BEACH CONFERENCE

On November 29, 1958, 122 psychologists met in Miami Beach to discuss graduate education in psychology. The conference, which continued for 9 days, centered around the discussion of 5 major questions: (1) What is the relationship between academic training and the various roles filled by psychologists? (2) Is there an educational curriculum basic to all psychologists regardless of specialization? (3) When and how much specialization should occur in graduate training of psychologists? (4) What kind of training should be given to the beginning graduate students? (5) What standards or accreditation should be established for graduate education?

The following is the summary chapter of the complete report of the conference. It seems appropriate to publish this chapter for ASHA Members so that they may keep abreast of developments in other professional organizations. Certainly the problems discussed relating to the impact of academic programs on a clinical field are similar to those in our own profession.

GRADUATE EDUCATION IN PSYCHOLOGY

Chapter 9 — Summary*

THIS Conference on Graduate Education in Psychology was organized by the Education and Training Board of the American Psychological Association, and supported by a grant from the National Institute of Mental Health. The 122 participants came from 65 colleges and universities in the United States and Canada, from 6 governmental organizations, 8 hospitals, clinics and special schools, 3 public school systems, 1 foundation and 1 accrediting agency. They also represented all specialties in psychology. They spent 8 days in animated discussion in large and small groups. They considered many problems on many different levels of complexity and importance. They disagreed on some of these problems, declined to debate others, and came to consensus on solutions to some, although the proposed solutions often raised further problems.

The members of this Conference were constantly mindful of the present severe disparity between the demands for the services of psychologists and the number of psychologists available to meet these demands, and of the expectation that this disparity would rapidly increase. This forced a very realistic reappraisal of the appropriate roles of psychologists. Out of this came four considerations: a reaffirmation that a psychologist is trained at the doctoral level; an emphasis on the necessity for committing a much

*Reprinted from "Graduate Education in Psychology," a Report of the American Psychological Association's Miami Beach Conference, (Nov. 29-Dec. 7, 1958), prepared and published by the Editorial Committee of the American Psychological Association, 1959.

larger share of our resources to the teaching of psychology; a re-examination of nondoctoral education in psychology; and a plea for creative innovation in devising means for meeting many of these needs that would spread our resources more widely than does the usual pattern in the synergetic specialties.

All previous conferences on graduate education in psychology have at least mentioned the necessity for nondoctoral education in psychology and related specialties, but no previous conference has attempted to grapple with this. The Miami Beach Conference believed that nondoctoral programs specifically for the training of teachers of psychology (for junior and small colleges, perhaps for high schools) should be extensively developed. It approved the participation of psychologists in training at the nondocto al level for specific service roles, in cooperation with other disciplines.

It approved, also, of the identification of psychological skills which can be learned adequately in one or two years of graduate work, and applied effectively (under appropriate supervision) without the broad background knowledge and the research training which this Conference unequivocally supported as essential for doctoral training in psychology. It did not identify these skills, nor offer curricula for training in them. It did ask the Education and Training Board to begin work on the problem. It recognized that for the technical specialties which are primarily psychological in nature there would be many difficulties involving such matters as titles and status, and it attempted at least a start at coping with these.

Discussions of the common core in psychological training brought out agreement that there is, in effect, a common core, but the Conference (unlike all previous Conferences) refused to specify this in terms of course content, preferring to leave it to each department to select, from the totality of psychological knowledge, whatever sampling best fitted the needs of its program and the capacities of its faculty.

It was, however, agreed that the defining characteristic of the psychologist is his research training. The Conference approved a broad definition of research to include a continuum of research methodologies from the most rigid hypothesis testing to the use of clinical and naturalistic devices for the formulation of communicable and testable generalizations. It approved early and extensive experience with research for all doctoral candidates.

The Conference discussed specialty training at the Ph.D. level (as distinct from nondoctoral technical training), and agreed that it should be structured within the broad goal of developing well-rounded psychologists. If specialization is to be carried out in such a way as to interfere with the student's understanding of basic psychological principles, then it should be delayed as long as possible, perhaps to postdoctoral years. If it can be carried out in such a way as to illustrate and clarify the application of basic psychological principles, it should be introduced as early in the doctoral program as it can be made to serve this function.

No definite stand was taken on the timing of the internship for those specialties which require one. The Conference noted that various plans are presently in use, and went on record as approving experimentation, and as suggesting that accrediting bodies and fund granting agencies should not restrict institutions which begin some carefully considered innovations.

Considerable dissatisfaction was expressed with the coordination of the work of internship facilities and universities. It was strongly asserted that the university has primary responsibility for this, and a number of suggestions for more effective collaboration were made.

There was clear sentiment for the improvement and increase of facilities for postdoctoral education in all specialties, but there was also strong objection to extending the formalized training to be required of a psychologist. It was accepted that the professional development of any psychologist involved continued learning throughout his life.

There was strong sentiment for innovation, not only in graduate and postgraduate programs, but also in research aimed at finding other ways than are presently available to cope with the massive service needs. It was felt that this is a challenge which psychologists are, or should be, uniquely fitted to take up.

There was strong consensus that some form of accreditation is necessary, and full agreement that the American Psychological Association was the most appropriate agency. There were repeated cautions against pressures to conformity. Majority opinion favored going beyond present accreditation policy, but with great circumspection. There was strong support for extension of accreditation to postdoctoral centers for training in the synergetic specialties. It was further suggested that there should be accreditation of nondoctoral programs as these develop, but the Education and Training Board was given no criteria to follow in either case.

It was recommended that the American Psychological Association develop some mechanism, independent of any accrediting function, for providing advice to departments for improving their programs in psychology at any level.

Finally, a striking aspect of the Conference was the great cohesiveness demonstrated; the often expressed fears of imminent fractionation of psychology seem quite unfounded in December, 195[illegible].

Legislation

CONNECTICUT AND OREGON LEGISLATIVE ACTIVITY

A considerable amount of state legislative activity has taken place during the past 12 months. The basic focus of this legislation in each instance revolved around the problem of licensing for hearing aid dealers. Legislation was introduced in Connecticut and Oregon and may be planned in California following a study to be conducted by the Senate Fact-Finding Committee on Public Health and Safety of the California Legislature.

LEGISLATION IN CONNECTICUT

The Connecticut bill, "The Licensing and Regulation of the Practice of Audiometry and the Dispensing of Hearing Aid Instruments and Devices in the State of Connecticut (Bill No. 834)" was introduced to the Connecticut General Assembly by State Senator Armentano on January 21, 1959. Its basic purpose was to call for the licensing of hearing aid dealers in the state of Connecticut.

This bill, backed by the hearing aid dealers, called for the licensing of the practice of audiometry and of audiometrists. It stated that " . . . there shall be a Commission of Audiometrists consisting of five persons, four of whom shall be licensed and registered audiometrists in this state, with at least 5 years practical experience in this state, and, at the time of their appointment, shall be actively engaged as audiometrists in this state; and one of whom shall be a licensed physician, preferably engaged at the time of his appointment, as an Otologist in this state. No fewer than three of said Commissioners shall be owners of hearing aid establishments, stores, shops or offices. On or before July 1, 1959, and quadrennially thereafter, the governor shall appoint 5 commissioners, who may be selected from a list of names submitted by the Connecticut Hearing Aid Society, for a term of 4 years. All such Commissioners shall continue to hold office until their successors have been appointed and have qualified."

A licensed audiometrist for the purposes of this legislation was defined as: "One having a knowledge of the structure and function of the human ear and skilled in the technique, other than by drugs, of measuring the power of hearing and the adaptation and fitting of hearing aids to the ears."

The sale of hearing aids was regulated by a section of the bill which stated that " . . . no hearing aids or accessory products or other instruments to aid hearing shall be sold at retail except under the supervision of a licensed audiometrist and in a licensed hearing aid establishment, office or store. Any hearing aid establishment, office or store, not under the supervision of a licensed audiometrist may sell hearing aid articles upon a permit to so sell, which may be issued by said commission, provided such permit shall specify the articles which may be sold."

Physicians and surgeons authorized to practice under the laws of Connecticut were exempted from licensing. Public and private schools for the deaf, Federal, State or Municipal Institutions and Hospitals or Clinics engaged in the treatment and care of the deaf were also exempted from licensing.

Action on the bill was delayed for at least two years, according to an article in the *Hartford Times* on April 23, 1959. This delay was made by the action of the Senate Public Health and Safety Committee which referred it to the Legislative Council for study. Chairman Norman Hewitt of the Public Health and Safety Committee indicated that "because this is a problem which affects the hard-of-hearing of our state and because the medical implications have not been fully explored, the Committee believes that a proper course on this bill is to refer it to the Legislative Council for further study and recommendation."

That this is a piece of unsatisfactory legislation is best expressed by the strong opposition to this bill on the part of the professional people of the state of Connecticut. These groups included the Connecticut Medical Society, The State Departments of Education and of Health, Connecticut Speech and Hearing Association and the Hartford Hearing League. To these groups definition of such terms as "fitting," selling and dispensing appeared to be inadequate and the licensing of hearing aid dealers as "audiometrists" warranted intensive discussion.

There is a feeling among some professional individuals in Connecticut that the time will come when all hearing aid dealers will be licensed. It may be hoped that when the time comes for such legislation, the legislative proposals will be drawn up as a cooperative effort by professional people such as physicians, audiologists and state legislative personnel as well as the hearing aid dealers themselves and representatives of the Hearing Aid Industry Conference. Such a move would be in direct contrast to the legislative activity in Connecticut which included the efforts of only the hearing aid dealers without the cooperation of the professional groups involved or the Hearing Aid Industry Conference.

Geraldine Garrison, the ASHA liaison representative in Connecticut, has kept the Association informed of legislative happenings in Connecticut and will continue to keep the Association and its members informed of further developments in this legislation. Dr. Edward Mysak will function in a responsible capacity for ASHA should this legislation reappear in Connecticut.

OREGON LICENSE FOR HEARING AID DEALERS

The recent enactment of a bill by the 1959 Oregon Legislature to license and regulate the sale of hearing aids presents several problems of importance to ASHA and to the profession of audiology.

It was reported that the legislative proposal stemmed from numerous written and oral complaints received by the Better Business Bureau from hearing aid users who had been victimized by bad business practices and personal deficiencies of one or two hearing aid dealers. These dealers were pictured as totally unfit and untrained to give hearing tests and fit hearing aids. Complaints were concerned with poor results from the use of hearing aids which had been bought with high expectations. Other letters stated that it was impossible to get proper service in keeping with the manufacturer's guarantee. Complaints were made which had to do with excessive prices for the hearing aids as well as customers being gouged by high interest rates on contracts. Misleading advertising and the bad practices of a few dealers in "fitting" children were also cited.

Hearing aid dealers in Oregon reportedly first learned about this proposed legislation one day before it was scheduled for its first hearing before a subcommittee of the Legislature. They assumed that the plan of restricting this information was a strategy move made by the proponents of the bill. Presumably this plan was effected to limit opposition forces from forming within the hearing aid dealer organization.

The original bill drew heavily upon existing law relating to optometrists. In bare outline, it provided for a three-man State Board of Hearing Examiners with jurisdiction over all persons who "fitted" hearing aids except those licensed to practice medicine or those employed by public or non-profit institutions. The board was to be composed of an otolaryngologist, a holder of an Advanced Certificate with ASHA, and a registrant under the act. The board was to be empowered to examine, grant and withhold certificates. This legislation called for the licensing of only hearing aid dealers who "fit" hearing aids. "Fitting" in the language of the bill was stated to mean " . . . evaluating or measuring human hearing by means of an audiometer (or other means) and the consequent selection or adaptation of hearing aids intended to compensate for hearing loss." In effect, the bill did not prohibit the sale of complete, ready-to-wear hearing aids as merchandise from a permanent place of business as long as the salesman did not hold himself out "as competent to examine and prescribe for the human ear." Physicians were exempted from licensing, as was "a person while he is engaged in the practice of fitting hearing aids if his practice is part of an academic curriculum of an accredited institution of higher education or part of a program conducted by a public, charitable institution or nonprofit organization, which is primarily supported by voluntary contribution." For others a qualifying examination was required.

Hearing aid dealers organized their forces to fight the discriminatory practices suggested in this bill. A series of hearings were held by Committees of the Oregon Legislature during which time the proponents of the bill and the dealers became deeply embroiled over the issues of "fitting" and the regulations imposed by the bill.

Prominent audiologists submitted telegrams of opposition to the Senate Committee selected to study this bill. In summary, it may best be stated that many audiologists did not feel that this was appropriate legislation for the regulation of hearing aid sales from the standpoint of professional management of hearing problems. It was felt that the Oregon Legislature was purporting to license individuals to do something which was not technically feasible. Robert L. Mulder, Oregon Liaison Representative for ASHA, presented the position of the Association. The basic points of opposition made by members of the Association were as follows:

House Bill 549 was designed to protect the public by licensing individuals to "fit" hearing aids. Basic to this legislation is the assumption that hearing aids can be "fitted" in a manner similar to the fitting of eye glasses. In the opinion of the many professional audiologists who directed letters to the Senate Committee, there was scientific evidence to support the fact that hearing aids cannot be fitted in this manner and therefore this was empty legislation. Further, it was felt that because the general public would associate the "fitting" of eyeglasses to the "fitting" of hearing aids this legislation would tend to confuse and deceive the public. In addition, audiologists felt this legislation would promote a concept of hearing aid dealers as professional persons rather than as skilled and competent members of a commercial group. Finally, it was believed that the proposed legislation would not provide proper regulation of advertising practices.

However, once the legislation began to "roll" and come to the attention of the public and legislators it appeared as if there was going to have to be some type of legislation effected to appease the public and legislative groups involved. While members of ASHA had certain kinds of objections to this legislation, the

majority of hearing aid dealers also objected to the legislation on somewhat different grounds. In an attempt to block some of the negative elements in the original bill, a substitute bill was presented by the dealers.

The dealer sponsored substitute bill required that the State Board of Health license all persons to either fit or sell hearing aids. It made certain behavior, including misrepresentation, a misdemeanor. It required that the registrant be a person of good character, but no examination was specified. It exempted only physicians and surgeons from the licensing requirement. It further required the posting of a $1,000 bond to insure "complete and adequate performance of all contracts, sales, and warranties." It also called for a code of ethics. The dealers felt this bill was more realistic and provided some greater degree of protection for the public. Moreover, it did not encourage the sale of hearing aids without "fitting procedures," as the original bill did. This substitute bill was then presented to the Committee but after lengthy discussion the dealers were unable to effect substitution.

Following further negotiations, revisions and a series of amendments a bill was passed by the House and referred to the Senate. The principal amendments made to the bill were:

(a) Inclusion of all persons who sold, as well as fitted hearing aids.
(b) Elimination of registration in each county.
(c) Elimination of bans on solicitation, except from a fixed place of business.
(d) Giving the dealers a majority on the Advisory Council.
(e) Assigning the Advisory Council the duty of preparing examinations.
(f) Elimination of a rule making power in the State Board of Health.

The amendments were accepted by the proponents of the bill and the bill went through both Legislative Houses and was signed into law.

IMPLICATIONS

The implication that a hearing aid can be "fitted" to a loss of hearing much as eyeglasses are precisely ground and fitted to compensate for loss of vision has been a particularly unfortunate feature in the use of the term "fitting" when applied to the sale of hearing aids. Serious doubts exist that standards of service to the public can be raised in this fashion. The community is likely to be confused, if not deceived, by apparent but not actual scientific and professional credentials. Overwhelming scientific evidence has shown us again and again that hearing aids *cannot* be fitted to people with hearing loss in a way similar to the prescription of eyeglasses. Certainly proper treatment of children and adults with hearing problems requires the diagnostic and therapeutic skill of physicians, audiologists and other related specialists if success in rehabilitation is to be accomplished.

A closer observation of persons exempted from this legislation should focus on the statement that indicates that "This Act does not apply to a person while he is engaged in the practice of fitting hearing aids if his practice is part of an academic curriculum of an accredited institution of higher education or part of a program conducted by a public, charitable institution or nonprofit organization, which is primarily supported by voluntary contribution." The meaning of the word "primarily" as used in the above statement may very well become a problem. It is possible that this legislation may be interpreted by the courts so as to require individuals who evaluate hearing aids in Community Hearing and Speech Centers to be licensed under this act if the Center receives more than 50% of its income from fees derived from services rendered. It is also reasonable to assume that private practice of audiology would not be permitted to include the evaluation of hearing aids except for individuals licensed under this act. It appears as if both of these possibilities would tend to restrict activity in the field of Audiology in Oregon to a considerable extent.

If we are realists, we should be aware that the question is not whether there will be licensing in the field of hearing but when and how this licensing will come about. Licensing laws come into existence for the protection of the public and since they are in the interest of the people they presumably will be enacted, whether or not the body being licensed favors or opposes them. The national organizations involved such as the Hearing Aid Industry Conference, The Society of Hearing Aid Audiologists, and the ASHA generally do not look favorably on such legislation at this time. While each group has its own and different reasons for opposing legislative efforts, major opposition stems from the belief that legislation "favorable" to any group would be difficult to obtain. But more important there is general concern for legislation which may be ill conceived, unrealistic in its basic goals and designed to punish the hearing aid industry rather than protect the public. Legislation can and should help the public as well as the groups it attempts to regulate. However, as may prove to be the case in Oregon, a bill which starts out with what appears to be "a move toward greater justice" for the public may well end up penalizing the very group it started out to protect. As we have indicated the Oregon legislation may easily mislead the hard-of-hearing to view the person licensed to "fit" hearing aids as being capable of examining and prescribing to alleviate their hearing impairments. It may even draw the hard-of-hearing individual away from an initial consultation with a physician as a necessary first step for the diagnosis of his hearing loss, or away from the

Hearing and Speech Center for consultative and rehabilitation services. Licensing may also provide legal sanction for a type of advertising which could be misconstrued by the public with respect to benefits obtainable through examination and "fitting" by a "licensed hearing aid dealer."

As we will discover licensing creates many problems. Licensing in Oregon is not an end. It is only a beginning. Even as we read and discuss legislation in Oregon and Connecticut, other hearing aid probes are taking place.

Hearing aids sales activities will be investigated by the Senate Fact-Finding Committee on Public Health and Safety of the California Legislature. Senator John F. Thompson, Chairman of this Committee, stated that reports of "a great many abuses in this field" prompted the committee to plan intensive studies to determine the feasibility of licensing hearing aid dealers.

In view of this forthcoming investigation, the hearing aid dealers of California have already created an organization that includes dealers from all parts of the state. The purpose of this group is to regulate their industry from within and to discourage politicians from sponsoring licensing legislation which would not be equitable to the hearing aid industry or in the best interest of the general public.

The implications of these actions by legislators and hearing aid dealers for the field of Audiology are great. The field of Audiology has much to lose through legislation designed to control the activities of others. But we may hope that when licensing efforts do spring up in the future they will be the result of the efforts of all organizations involved and not the result of the activities of special interest groups. We may hope that the public will be the beneficiary of any licensing in this field. Our personal feeling is that helpful legislation is not probable at this time.

S.L.B.

THE NEED FOR ADEQUATELY TRAINED SPEECH PATHOLOGISTS AND AUDIOLOGISTS

THE following statement prepared by the Liaison Subcommittee on Legislation of ASHA is provided to give assistance to members of the Association who may be called upon to provide testimony at the hearings before the Senate Committee on Labor and Public Welfare, the House Subcommittee on Special Education and the Frampton Study Committee Workshops. The Frampton Study Committee Workshops although not directly related to the eventual passage of S.J. Res. 127, H.J. Res. 488, H.J. Res. 494, etc., are indirectly related to the passage of this legislation. This Study Committee is serving as a resource committee for the House Subcommittee on Special Education and Rehabilitation. Its purpose is to provide information to key members of Congress regarding the problems in the field of special education and rehabilitation. The information contained in the following statement may prove helpful to their understanding of the needs in our field and assist them toward the development of appropriate future legislation for individuals in need of special education and rehabilitation services.

ASHA Committee
on Legislation

WITHIN the total population of handicapped children in the United States the largest group consists of children with speech and hearing problems. By 1960 more than three million children will have speech or hearing that is so seriously impaired that it can and frequently will interfere with their educational, social and emotional adjustment.

The most recent estimate is that 5% of our 49,800,000 school-age children and at least 1.3% of our 21,019,000 children under five years of age have speech problems. An additional 0.7% of our school-age children and 0.3% of our preschool-age children have handicapping hearing problems (These populations do not include Alaska, Hawaii or Puerto Rico).

If we take a typical city of 40,000 population we would expect the school population to be about 10,000. Table I presents the estimated number of these

Table I. EST. NO. OF SCHOOL-AGE CHILDREN PER 10,000 WITH EACH TYPE OF SPEECH OR HEARING PROBLEM

Type of Problem	% of Children with Serious Problems	Children with Serious Problems
Articulation	3.0	300
Stuttering	1.0	100
Voice	0.1	10
Cleft Palate Speech	0.1	10
Cerebral Palsy Speech	0.1	10
Retarded Speech Developments	0.2	20
Speech Problem due to Impaired Hearing	0.5	50
Total	5.0	500

10,000 school-age children with each type of speech problem.

The above estimates are believed to be conservative, and in each instance err on the side of underestimating the number of children with speech and hearing problems. For example, it should be noted that only children with significant or handicapping hearing losses are included above. An additional one million school children have nonhandicapping reductions in hearing acuity.

Data on the prevalence of speech and hearing problems in adults are not as complete as are the data for the population of school-age children. A recent estimate places the incidence at 3.0% of the population over 19 years of age having speech problems and 2.1% having handicapping hearing problems. Thus, over six and a half million American adults are believed to have speech or hearing problems as of 1960.

In addition to the prevalence estimates for the continental United States, when the over-all incidence figures of 3.4% for speech problems and 1.5% for handicapping hearing problems are applied to the populations of Alaska, Hawaii and Puerto Rico an additional 147,000 individuals are included.

In summary, there are believed to be nearly nine million Americans with speech and hearing problems as of 1960. The over-all incidence and prevalence figures are shown in Table II.

Table II. EST. INCIDENCE AND PREVALENCE OF SPEECH AND HEARING PROBLEMS AMONG U. S. 1960 POP.
(Continental U. S., Alaska, Hawaii, and Puerto Rico)

1960 Pop.	Incidence, Speech Problems	Prevalence, Speech Problems	Incidence, Significant Hearing Problems	Prevalence, Significant Hearing Problems
Under 5 yrs. (Continental U.S.) 21,019,000	1.3%	262,737	0.3%	63,057
5 - 19 yrs. (Continental U.S.) 49,782,000	5.0%	2,489,100	0.7%	348,474
Over 19 yrs. (Continental U.S.) 110,353,000	3.0%	3,310,590	2.1%	2,317,413
Alaska, Hawaii and Puerto Rico (total, all ages) 3,000,000	3.4%	102,000	1.5%	45,000
Total Pop. 184,154,000	Total (Speech)	6,164,427	Total (Hearing)	2,773,944
	Grand Total (Speech and Hearing)			8,938,371

To meet the needs of the speech-and-hearing-handicapped children and adults in the United States would require over 32,000 adequately trained speech pathologists and audiologists. Good practice suggests a case load of not more than 100 children per clinician in a public school speech program. A total of 25,000 clinicians would be needed to serve the needs of the 2,500,000 speech and hearing impaired school children in the United States.

The Office of Vocational Rehabilitation has estimated the need for one speech pathologist and one audiologist per 50,000 population *providing a strong speech and hearing program is operating in the schools.* To meet the needs of the adult speech and hearing group over 7,300 trained personnel would be required. These 7,300 added to the 25,000 needed for school-age children make a total of 32,300 competent professional people needed in the fields of speech and hearing. The need for over 32,000 speech pathologists and audiologists is in sharp contrast to the present supply of about 2,000 certificated and 5,000 non-certificated personnel in the speech and hearing field.

If we set an exceedingly conservative goal of only 20,000 rather than the 32,000 trained people needed 10 years from now, we must train 1,500 per year for each of the next 10 years. The training of 1,500 clinicians per year would result in the training of 15,000 over a 10-year period. These 15,000 added to the present 2,000 certificated and 5,000 non-certificated personnel would result in a total of 22,000. By allowing 10% loss through marriage and other factors, this results in approximately 20,000. If we wish to have 20,000 trained personnel to meet the needs of the speech and hearing handicapped in 1970 then we must immediately begin to train 1,500 clinicians each year.

This figure of 1,500 clinicians is far from the 400 people currently being trained in the speech and hearing field each year. The problem is even more acute when we consider the shortage of university personnel needed to train the future clinicians. In 1956 only 34 doctorate degrees in speech pathology and audiology were granted. By 1957, the number had increased to 37.

At the present time, there are 30 schools training at the Doctorate level and 40 training at the Master's level. To provide each of these training centers with additional staff and equipment to upgrade and expand training facilities would require on the average (based on Office of Vocational Rehabilitation experience of the past two years) $11,000 per school per year, or a total of $770,000 per year. If government support were to be provided for one-third of the needed 1,500 personnel we must train each year and if this support were to be at the current average of Office of Vocational Rehabilitation traineeships (approximately $2,500 per year) $1,250,000 would be needed annually for traineeships. The combined annual cost of the teaching grants to 70 schools and training grants of 500 trainees would come to a total of approximately $2,000,000.

At the present time, this would appear to be the only feasible method to begin to secure the personnel required if we are to make useful taxpaying citizens of the millions of speech and hearing handicapped in the United States–most of whom are presently not receiving professional help with their handicap because of this desperate shortage of trained personnel in the speech and hearing field.

Your Committees in Action

A MASTER HEARING AID

THE Hearing Aid Industry Conference (HAIC), an organization representing many of the major manufacturers of hearing aids, has for some time expressed concern over the cost of providing an inventory of hearing aids to audiology clinics and centers throughout the country. Spokesmen for HAIC have estimated this inventory at approximately one million dollars, with about one-quarter of a million dollars additional loss each year due to obsolescence. The HAIC has considered the development of a Master Hearing Aid as a possible solution to the problem, virtually eliminating the need for maintaining a stock of trial aids in the centers and clinics. On action of the President of ASHA, Dr. Moe Bergman was appointed to serve as Chairman of a committee of audiologists to meet with representatives of the HAIC during the latter's Annual Meeting in New York City, for the purpose of exploring the Master Hearing Aid idea. The meeting was held on April 27, 1959 at the Barbizon Plaza Hotel.

The Chairman of the Master Hearing Aid Committee of HAIC, Mr. David Barnow, stated that, in view of the increasing number of models being marketed by the industry, and because of the growing list of audiology clinics and centers, the industry wished to study the possibility of using the "Master Hearing Aid" to arrive at a "prescription" for each patient in the audiology programs, without resort to a library of representative models. It was reported that an engineer had been developing plans for such a master aid and material describing the electro-acoustic performance of the proposed instrument was circulated. Briefly, the proposed Master Hearing Aid would have two separate and complete channels, with external microphones which could be mounted on the head for either monaural or binaural application, or on the body in "conventional" manner. The instrument would be constructed from standard hearing aid parts and would be designed to incorporate the approximate distortion characteristics of commercially available hearing aids. There would be three variables in its performance: 1) gain, for which there would be a control with five db steps, permitting a gain range from approximately 30 to 75 db; 2) maximum power output, with a control in 10 db steps permitting a range from 110 db through 140 db; and 3) frequency response adjustment, to provide four different frequency contours. The discussion of the idea produced many questions, including the following:

Would the information obtained on the Master Hearing Aid be applicable to commercial hearing aids? It was generally agreed that an essential preliminary step would be for hearing aid manufacturers to agree upon a standard method of specifying the electro-acoustic performance of their models. At the present time there is a variety of systems for evaluating and for specifying gain, output and distortion. It appeared that the use of the master aid to arrive at a "prescription" or "description" of electro-acoustic performance would be applicable only to those hearing aid models whose characteristics were evaluated and specified in a manner similar to that of the master aid.

What important factors of performance would not be compared by the Master Hearing Aid? Since the variables planned by the HAIC for incorporation in the master aid include only gain, output and frequency response, it appeared that there would be no control of other factors which may influence the benefits to be derived from a wearable hearing aid, such as distortion characteristics, output limiting methods, such as peak clipping, automatic volume control and compression, including in the latter, the attack and release times, and the various aspects of transient response. One of the conferees, a hearing aid engineer, stated his conviction that distortion, in particular, varies from model to model to a degree which is significant.

What would be the effect of the introduction of new hearing aid models by the manufacturers on the continuing validity of the master aid's prescriptions? The variable of the master aid which is in question here appears to be that of frequency response. A representative of the industry expressed the opinion that the response curves of the proposed master aid were generally characteristic of those of commercial aids, and that minor variations in frequency were not as important as variations in gain and maximum output. This point seemed to call for further documentation.

Editor's Note: This Report was prepared by Moe Bergman, Ed.D., Chairman of the ASHA Ad Hoc Committee on the Master Hearing Aid. Other members of this Committee were Martin Cohen, M.A., William G. Hardy, Sc.D., Kenneth O. Johnson, Ph.D., Donald M. Markle, Ph.D., and Howard Ruhm, Ph.D.

How would the selection of a commercial hearing aid be accomplished after the desirable performance characteristics had been indicated by the Master Hearing Aid? The following *modus operandi* was suggested by representatives of HAIC. The audiologist would advise the patient that he required a hearing aid with a set of characteristics as stated in the prescription. The patient would then go to a dealer of his choice or to hearing aid dealers suggested by the audiologist. When the patient made his selection it would be understood that he would be permitted to take the instrument out on loan for a test or a series of tests at the audiology center before final purchase was consumated. The question of cooperation in such a program by individual hearing aid dealers was considered by the conferees. The HAIC representatives agreed that there would be no assurance of such cooperation, which would have to be given by each dealer voluntarily.

How would the applicability of the Master Hearing Aid be evaluated? It was urged that before any conclusions be drawn about the use of the master aid, its evaluation should be based upon valid criteria determined in advance of trials in centers and revised as developments dictate. A representative of HAIC suggested that the whole idea of the Master Hearing Aid and its function be considered in detail by a joint ASHA-HAIC committee. Since the purpose of the present discussion was informal exploration, no further action was taken on this suggestion.

In summary, it appears that the manufacturers are deeply concerned with the cost of providing stocks of hearing aids to audiology centers and clinics. They are investigating the possibility that a Master Hearing Aid may eliminate the necessity for the maintenance of such stocks, have made considerable progress toward the development of a prototype instrument, and are desirous of engaging the cooperation of some centers or clinics in a trial of its feasibility and applicability.

It is the feeling of the members of the ASHA Committee that we should continue to cooperate to help the manufacturers reduce unnecessary costs incurred in the stocking of representative models in the centers and clinics. It was agreed by all at the meeting, for example, that hearing aid inventories could be more judiciously distributed through the strengthening of professional standards for hearing centers and clinics. It was suggested further that certification of centers and clinics by ASHA would contribute significantly to the proportionate increase in the numbers of such establishments with which the industry could cooperate with confidence.

It appears that considerable additional discussion and planning are essential in connection with the development and use of the Master Hearing Aid.

1001

Speech Pathologists and Audiologists Convention Vintage 1958

WHO comes to conventions? Drawing on the results of a questionnaire completed by 2,100 members of the 2,522 registrants who attended the New York Convention we are in a position to observe more closely the ASHA Conventioneer. The remainder of the registrants not included in these findings were associates or nonmembers. Included in this questionnaire were such data as general composition of the membership, areas of primary interest, nature of current activity, age, degree status and general income range. The following seemed to be the state of things.

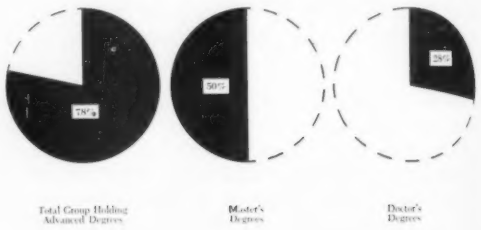
Attendance at the convention appeared to be determined, for the most part, by geographical proximity with 44% of the members responding coming from within a radius of 500 miles of the convention site. Thirty percent traveled from points 500 to 1,000 miles away and another 26% of the group traveled 1,000 miles and over to reach the convention point. They came to the convention in everything but horse and buggy with plane travel accounting for 44% of the group. Twenty-eight percent drove to the convention in private cars while 19% decided to take the train. Another 7% decided to "leave the driving to us" and came by bus. A minority group of New Yorkers, presumably, commuted which must include the more hearty ones who walked, rode motor bikes or bicycles. It is because of findings such as these that our Committee on Time and Place follows the policy of holding conventions in different sections of the country in successive years.

A closer look at these members indicated that 52% were male and 48% female and of this group 63% were married. Fifty-three percent of this group had joined ASHA within the past 5 years while 29% had been members for 6 to 10 years and 18% for 11 years and over.

The fact that ours is a young, vigorous organization is re-emphasized by the fact that 42% of the members responding were under 30 years of age. Thirty-three percent confessed to being between 30 to 40 years of age including several who professed to being "only 39." Nineteen percent of the members were between 41 to 50 years of age while 6% were over 51. This could possibly prove that the older you are the less vigor and stamina you have to attend conventions but we prefer to feel that it more realistically supports the thesis that ours is a young energetic group of professionals in a rapidly growing field.

It is most interesting and indeed gratifying to note the large incidence of advanced degrees within this field as expressed in Table I—Degree Levels. This

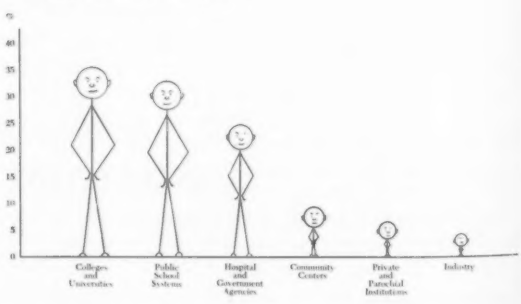
Table I—DEGREE LEVELS



could possibly be an indication of our intent to rise above the Bachelor's degree as a terminal degree in the field of speech and hearing and a movement toward full professional stature.

A closer observation of the members responding with respect to the location of their principal work indicated that there were approximately the same number of individuals associated with colleges and universities as were working in the public school systems. Another large group of respondents were to be found working in hospitals and governmental agencies. The remainder were located in such installations as community centers, medical schools, private or parochial institutions, teacher's colleges and industry. This information is shown in Table II—Location of Principal Work. It is most interesting to note

Table II—LOCATION OF PRINCIPAL WORK

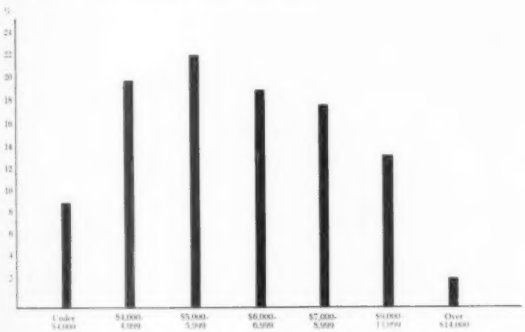


the many and varied placement possibilities available to the average speech pathologist or audiologist. Representation in such a multitude of settings allows us to spread knowledge of our profession to specialists in allied fields and increase our abilities to be of greater service to our patients and to other professions.

The principal type of work of 50% of the respondents proved to be clinical (including therapy in the public schools). Split assignments consisting of part clinical and part teaching accounted for 15% of the group. Twelve percent were involved in University and College teaching. Another 12% classified themselves as administrators. Six percent were involved in research activities. The remaining percentage of respondents were not too sure just exactly what it was that was keeping them busy 60 hours a week and felt great problems in attempting to classify their dilemma.

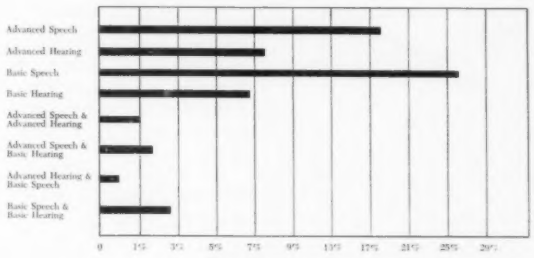
Income derived from professional activity by respondents disclosed that while 9% were making under $4,000 per year another 9% of the group were making over $10,000 per year. Fifty-one percent of the group indicated that they were making incomes ranging from $5,000 to $8,000 per year. Table III is a breakdown of derived incomes From Professional Activity for the entire group.

Table III—INCOME DERIVED FROM PROFESSIONAL ACTIVITY



Sixty-three percent of the respondents held certification. The certificate holders were distributed among the various classifications, as indicated in Table IV—Certification Levels.

Table IV—CERTIFICATION LEVELS



This has been a brief look at the ASHA Conventioneer, Vintage 1958. We have been able to observe his areas of primary interest, the nature of his current activity, his degree status, his certification level and his general income range. It should be apparent that the "vintage" in 1958 was a good year for the profession. It indicated a young, energetic, rigorous, well qualified group of individuals who were maintaining responsible positions in their respective communities and earning above the average income levels. Like wine, our ASHA Conventioneer will most certainly mellow with age and continue to expend his energies in developing the field of speech and hearing for the "young grapes" of the future.

S.L.B.

OMISSION CORRECTED

From the Report "National Study in Public School Speech and Hearing Services," appearing on page 61 of the October *Asha*, the name of **Dr. Rolland Van Hattum,** Director of Special Education, Kent County, Michigan, was omitted. Dr Van Hattum will serve as Vice-Chairman of Work-Group Area III, Program Management.

REPLACEMENT OF DAMAGED CERTIFICATES

IN October several hundred clinical certificates were mailed to members. A number of the mailing tubes were crushed before they reached these members. In several instances the certificates were ruined. If you received a damaged certificate please return it to the National Office for a replacement at no charge.

Clinical and Educational Materials

EQUIPMENT

GOVERNMENT EQUIPMENT ranging from navigation instruments, radio and photographic equipment, electric motors, spectrometers, chemicals, lenses, electronic items and components, are still available to universities and schools. A large part of this equipment, at the rate of $100 million each year, comes from the Department of Defense, the Atomic Energy Commission, laboratories of the Department of Agriculture and Veterans Administration. Many items are in the original packing cases. An institution can obtain this useful equipment by: (1) getting in touch with its state surplus property agency and establishing the institution's eligibility; (2) sending personnel to the warehouse to see what may be coming in or is in storage; (3) obtaining a list of items that some teacher would like for his classes; and (4) providing the state agency with a list of desired items so that the agency can obtain them as they become surplus.

AMBCO TRANSISTOR. Binaural Auditory Trainer, Model TTB. This battery operated transistor amplifier, housed in a metal case 2 × 2 × 6 inches with separate controls for each ear, can be obtained from A. M. Brooks Company, 1222 W. Washington Boulevard, Los Angeles 7, California.

AMPLIVOX—MODEL "81." A small portable unit incorporates filtered white noise masking and the use of a small insert earphone for applying the masking tone. In addition there is a high quality speech circuit with a hand microphone. Calibration can be either the British or American threshold. More information concerning the Model "81" may be secured by writing Amplivox Exports Limited Beresford, Wembley Middlesex or Amplivox (Canada) Limited, 71 Wellesley Street East, Toronto 5, Ontario.

BRUSH INSTRUMENTS have a number of specialized engineering and test instruments which have been used for demonstration or for special purposes. Available at special prices to nonprofit groups. Address: N. R. Klivans, Brush Instruments, 37th and Perkins Streets, Cleveland 14, Ohio.

DIAGNOSTIC INSTRUMENTS. Recently published 48-page catalogue of different types of diagnostic instruments produced by the National Instrument, Division of Engelhard Industries. Address: 92-21 Carona Avenue, Elmhurst 73, New York.

VOICE MASTER. A Japanese import consisting of a perforated plastic mouth piece which fits over the nose, mouth and chin and plastic tubes which may be plugged into one or both ears, permitting one to hear his own speech as it sounds to others. Distributors: Viking Importers, 13 South Edgemont Street, Los Angeles, California. $3.00

AUDIOMETER CALIBRATION. Portable calibration unit now available from Allison Laboratories, Inc., 11301 E. Ocean Avenue, La Habra, California.

PUBLICATIONS – OTHER MATERIALS

TOWARD UNDERSTANDING STUTTERING. Wendall Johnson, Ph.D., National Society for Crippled Children and Adults, 2023 W. Ogden Avenue, Chicago 12, Illinois. A 40-page pamphlet written especially for parents. Price: 25 cents.

A BIBLIOGRAPHY on lipreading has been compiled by Edward Jordan, LCST. Copies may be obtained from E. T. Jordan, Special Education Clinic, Indiana State Teachers College, Terre Haute, Indiana. Price: 25 cents.

REVIEW OF RESEARCH IN SPEECH AND LANGUAGE—*A Review of Research in Speech and Language Development of the Mentally Retarded Child*, by Sam Harrison; *Guide Posts for Helping Parent Associations Develop Programs of Education for Children with Cerebral Palsy*, by Joseph Fenton; *Cerebral Palsied Children and Their Parents*, by Elsa A. Miller. Address: United Cerebral Palsy Association, Inc., 321 W. 44th Street, New York 36, New York.

HOW CHILDREN LEARN TO SPEAK. M. M. Lewis, 1959. Basic Books, 59 4th Avenue, New York 3, New York. The publisher states that the British psychologist-sociologist of speech illustrates that there is an international baby language of six sounds with slight differences in vowel pronunciations. Babies everywhere use these earliest "noises" in learning the language of their surroundings, the first and biggest step, in the life long process of learning to communicate with others. Recommended as required reading for parents, grandparents, and pediatricians.

SPEECH CORRECTION THROUGH LISTENING.* Bryng Bryngelson, Ph.D., Elaine Mikalson, M.A., 1959 Scott, Foresman and Company, Chicago, Atlanta, Dallas, Palo Alto, and Fair Lawn, New Jersey. A comprehensive resource book for classroom teachers and speech correctionists which combines stories, Mikalson's previous recordings *Listen and Learn*, and games into a program of highly motivating fun, provoking activities for the correction of Articulatory problems.

LET'S PLAY HIDE AND SEEK, Activities Kit.* Ruth M. FitzSimmons, Ed.D., and Albert T. Murphy, Ph.D. Expression Company, Magnolia, Massachusetts. The authors rationale indicates that the materials: (1) large easel book of illustrations covering eleven practice sounds; (2)

*The above materials should meet an expressed need of Speech Correctionists, namely, having enough purposeful activities to maintain motivation until new sounds are sufficiently strengthened to become an integral part of an individual's connected speech.

manual which includes descriptions and word stimuli for each illustration; and (3) workbook, "utilize auditory, visual and tactile cues," to provide, "varied sequential practice which is designed to build sound mastery for the young speech handicapped child who has an articulatory problem and increased speech reading for the child who is hard of hearing."

THE BEST SPEECH SERIES.* Jack Mathews, Ph.D., Elizabeth Ruth Phillips, Jack W. Birch, Ph.D., and Ervest J. Burgi, Ph.D. In each of the work type manuals, *My Sound Book*, for the sounds S, R, Th, L, K, and G, the authors have combined means of diagnosis of specific difficulties on each sound, language development, ear training, sound discrimination, practice materials, and objective measures of progress. Published by Stanwix House, Inc., Pittsburgh, Pennsylvania.

HEARING WITH OUR EYES, BOOK II. Ena G. Macnutt. A new lipreading text with accompanying work book, for junior high school students which includes 27 lessons of gradually increasing complexity. Available from, Volta Bureau for the Deaf, 1537 35th St., N.W., Washington 7, D. C.

LIP READING SET. Pictures in bright poster colors, illustrating carefully chosen words in 14 categories. Double sets are available for use in matching games.

SPEECH AUDIOMETRY SET. For auditory training and speech work. Patterned after PB50 word lists. As of September, 1959, prices were reduced because of popular demand. Distributor: Visual Aid Materials Company, 3212 Butler Avenue, Los Angeles 66, California.

FILMS

SPEECH OF STUTTERERS BEFORE AND AFTER TREATMENT. Produced by Bryng Bryngelson, Ph.D., University of Minnesota. 16 mm, black and white, sound, 30 minutes. Designed for instructional purposes in speech pathology. Presents a group of out-patient stutterers, filmed over a period of 8 years as a part of a longitudinal study in environmental stress and strain. $150.00

A FUNCTIONAL STUDY OF THE TONGUE AND THE VELO-PHARYNGEAL MUSCULATURE. Sponsored by the Speech Clinic and the School of Dentistry of the University of Minnesota. 16 mm, color, sound, 7 minutes. $90.00

A STUDY OF VOCAL CORD ABNORMALITIES. Produced by Physical Medicine and Audio-Visual Department, University of Minnesota. 16 mm, color, sound, 14 minutes. $140.00. The above films may be purchased from Audio-Visual Education Service, Westbrook Hall, University of Minnesota, Minneapolis.

FILM STRIPS FOR PRACTICE IN PHONETIC SKILLS, Scott Foresman, Chicago, Atlanta, Dallas, Fair Lawn, N. J., Palo Alto. 4 films, black and white, furnish practice in (1) auditory perception of rhyme, (2) auditory perception of initial consonants, (3) visual auditory perception of initial consonants, (4) consonant substitutions. Provides an interesting media for practice for correct sounds contained in words in a basic reading program.

TALKING TIME FILM STRIPS, Louise Binder Scott, 1955, produced by David J. Goodman, distributed by Webster Publishing Company, St. Louis, Atlanta, Dallas, Pasadena. Two series, 15 different film strips, color. Pictures, which are most interesting to children, are designed to create an awareness of consonant sounds through visual, auditory and kinesthetic approaches, and to supply supplementary teaching and practice materials for instructors of hearing and speech handicapped children as well as for the classroom teacher. Especially adaptable for use with groups.

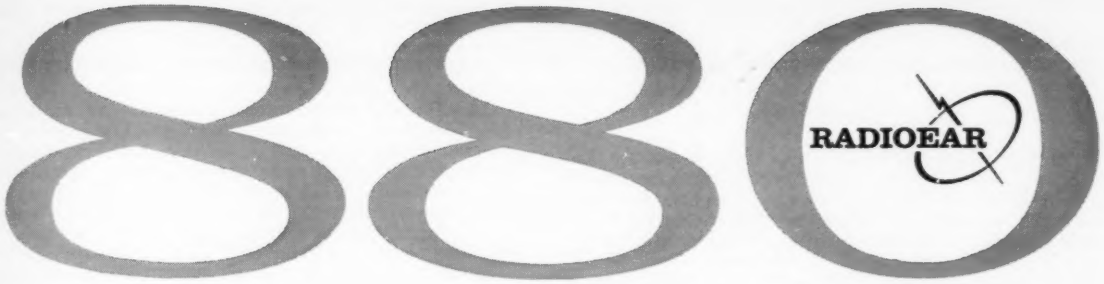
RECORDINGS

MULTIPLE CHOICE WORD LIST. Developed by Charles Hutton, Ph.D., E. Thayer Curry, Ph.D., and Mary Beth Armstrong, Hearing Center, University of Illinois. Suitable for testing auditory, visual and combined auditory-visual intelligibility. The recorded auditory test has been found to give rapid and reliable estimates for listening errors. Commercial disc and tape recordings are available to interested persons.

JUMBO MAGNAGRAM. A 24′ by 18′ black on white, thin gauged metal audiogram. With its 24 movable magnetic symbols—12 blue X's for the left ear and 12 red O's for the right ear—this instrument proves to be most effective for instruction and demonstration purposes. Distributors: Burrill Special Instruments, 1112 Hume Manser Bldg., Indianapolis, Indiana.

AUDITORY TRAINING ALBUM, Jean Utley, distributed by Maico Co., Inc., Minneapolis, Minnesota, and University of Illinois Press, Urbana, Illinois. 78 r.p.m., Album, 2 records. Records are to accompany workbook *What's Its Name?* This album, with its accompanying workbook, containing realistic, clear-cut illustrations has proved to be an excellent guide and aid to auditory training and speech development for the hearing child as well as the child with a hearing handicap.

RHYTHMIC ACTIVITIES, Volume IE71 and Volume IE72, RCA Victor, available in 45 r.p.m. or 78 r.p.m., Albums —4 records each. Through directed listening to this carefully selected strong rhythmic music a child may increase his tolerance for sound and his ability to discriminate between rhythms. Participation in rhythmic activities such as tapping, clapping, swinging, swaying, etc., affords an opportunity for self expression and may create in a child, a desire to respond, nonverbally before there is a readiness for speech.



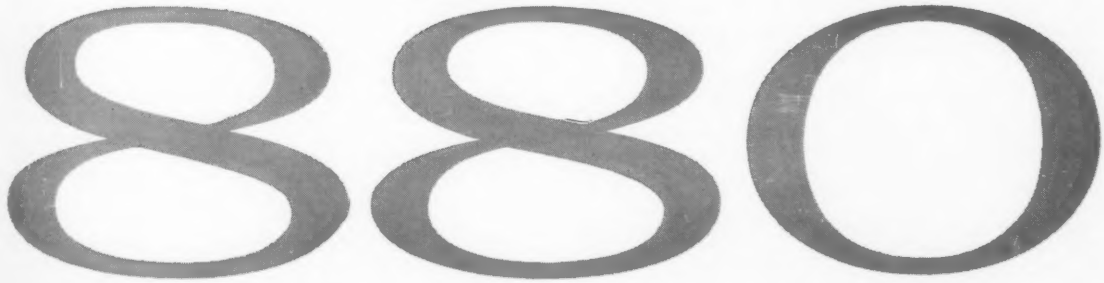
The introduction of the Radioear 880 marks the beginning of a whole new era in behind-the-ear aids. For the 880 is the result of an intensive research program that was aimed at incorporating the fittability and adjustability of a body type aid into the small size of a head-worn aid. Here are some of things that Radioear has accomplished in the remarkable new 880:

- **TELEPHONE PICKUP**—a genuine Radioear Phonemaster
- **TONE CONTROL**
- **FOUR GAIN ADJUSTMENTS**
- **TWO LEVELS OF SATURATION OUTPUT**
- **TWENTY-FOUR DIFFERENT FITTINGS AVAILABLE**

All in all, the 880 is completely different from what has gone before. With all its features, it is still small and lightweight—it provides a new low in distortion, and it provides clear, understandable hearing without the revealing receiver button in the ear. The 880 is indeed a users' instrument, since it gives them good hearing, and no service problems. The Radioear Golden Fidelity circuit is immediately replaceable—the tiny telephone switch gives clear telephone hearing with the phone held in the normal position—and the inconspicuous volume control is easily adjustable.

The new Radioear 880 is now available—take a look and be convinced.

RADIOEAR CORPORATION
Radioear Building
Valley Brook Road, Canonsburg, Pa.



News and Announcements

Organizational

An International *Symposium* for General and Applied Phonetics will be held in Hamburg in September, 1960. Formerly reported as a "congress," the title has been changed to avoid mistaking it for another congress which will be held in Helsinki in 1961. The objective of the conference is to bring closer contact between specialists in theoretical and practical phonetics from all over the world for the benefit of research and training.

The Subcommittee on Special Education of the Committee on Education and Labor of the United States House of Representatives held public hearings on October 28th and 29th in New York City, and received testimony pertinent to S.J. Res. 127 and H.J. Res. 488, concerning the training of speech pathologists and audiologists. Members of ASHA and other associations living in the New York vicinity were asked to give their testimony concerning the most urgent needs in this area of training specialists to work with hearing impaired persons. Dr. Bruce Siegenthaler represented ASHA at these hearings.

The American Cancer Society, Kentucky Division, has printed an educational brochure for the recently laryngectomized patient. The pamphlet, "Operation Voice Box," attempts to answer some of the most frequently asked questions regarding laryngectomy and offers suggestions for post-operative adjustment. Copies of this booklet may be secured from the American Cancer Society, Kentucky Division, Medical Arts Building, 1169 Eastern Parkway, Louisville, Kentucky.

For the first time in its history the Minnesota Speech and Hearing Association held a late summer workshop. From August 28 through August 30, about 40 clinicians from throughout the state met at Camp Courage, Annandale, Minnesota. The program featured two sessions of discussion on "Articulation Therapy" led by Dr. John V. Irwin, Director of the Speech and Hearing Clinic, University of Wisconsin. Other addresses were "History and Development of Speech Correction in Minnesota" by Dr. Bryng Bryngelson, Director of Speech Pathology, University of Minnesota; "Present and Future Thinking in Special Education" by James Geary, Director of Special Education, Minnesota State Department of Education; and "Listening" by George Shapiro, Speech Department, University of Minnesota. Two sessions were devoted to presentation of cases and to discussing various problems encountered by speech correctionists.

A Speech and Hearing Association has been organized for the first time in Rhode Island.

A directory of federal and private agencies working with the handicapped is available for 25¢ from the People to People Committee for the Handicapped, Room 205, 726 Jackson Place, Washington, D. C.

The Hearing Aid Industry Conference has adopted a code of ethical practice in the hearing aid field. Aimed at providing clear cut standards for manufacturers, distributors, dealers, and salesmen, the code places special emphasis on the following areas: "1) advertising and promotion announcements; 2) retail consulting such as testing and fitting of hearing aids; 3) research activities and; 4) servicing of industry products." Two examples of specific practices prohibited by the Code are: 1) "use of such terms as 'specialist,' 'clinic,' 'Hearing Center,' 'Institute,' and the like, to suggest they refer to the medical profession or educational and research institutions," and 2) "representing that medical services have been used to design or make a product or will be available in selecting, testing, or adjusting the product when such are not the fact." The industry also pledged that it will conduct independent research and also cooperate with other professional groups engaged in research to improve its products and their distribution.

The Officers of the Michigan Speech and Hearing Association for 1959-60 are: President, Keith L. Maxwell, Ph.D.; President-Elect, Ruth Curtis, M.A.; Vice-President, Mary Costello, Ph.D.; Secretary, Marjorie McMahon, M.A.; Treasurer, Ralph Rupp, M.A.; Member-at-Large, Gerald Freeman, Ph.D.

Institutional

Awards and Grants

Mary Lucille Atkinson, graduate student at Tulane University, and Agnes Lenard, graduate student at the State University of Iowa, have each been awarded a $500.00 scholarship by the American Speech and Hearing Foundation. These awards were made possible by a grant to the American Speech and Hearing Foundation by the United Cerebral Palsy Research and Educational Foundation.

A two-year study comparing the psycho-educational performance of day students and resident students in residential schools for the deaf will be sponsored by Gallaudet College through a $11,000 grant from the U. S. Office of Education. Stephen P. Quigley, Ph.D., and Robert Frisina, Ph.D., will direct the research.

A bibliography, *Reports Resulting from Research and Demonstrations Projects Supported by OVR*, has been published by the Division of Research Grants and Demonstrations of the Office of Vocational Rehabilitation. Of the 167 articles listed, 26 are listed under the category, Speech and Hearing.

The treatment, education, and rehabilitation of handicapped children ranks seventh in the list of 40 "concern" of states, as determined in preliminary meetings of the

Golden Anniversary White House Conference on Children and Adults. More than 7,000 participants from more than 500 organizations and representatives of the Governors of the States will meet in Washington, D. C., March 27-April 2, 1960. The Council of National Organizations has already held preliminary meetings September 21-22, 1959 to determine the critical needs of American youth. ASHA has made a contribution of $150 to the conference planning and programming, and will be represented at the meetings.

Programs

The Department of Hearing and Speech of the University of Kansas Medical Center, in cooperation with the Department of Postgraduate Medical Education, will offer the annual Hearing and Speech Conference on February 19-20, 1960. Speakers will include: Joseph Wepman, Ph.D., Miriam Pauls, Ph.D., and Charlotte Wells, Ph.D.

The Speech Correction Department of the Kansas City, Missouri Public Schools in conjunction with the Research Department is initiating a research project entitled "A Comparison of a Speech Improvement Program and Speech Correction Program for First Grade Pupils with Respect to Functional Articulation, Auditory Discrimination, and Enunciation in Spontaneous Speech." This research will be conducted in forty elementary schools. A Speech Correction program is in operation in each of the 81 elementary schools and 15 secondary schools in the school system.

The Hearing and Speech Department at the University of Kansas Medical Center is now housed in the recently completed Children's Rehabilitation Institute. Three new members have been added to the Speech Pathology and Audiology program at the University of Kansas: Ralph L. Shelton, Jr., Ph.D., Assistant Professor at the Medical Center; Harris Winitz, Ph.D., Research Associate in the Bureau of Child Research; and James N. Neelly, M.A., assistant director of Speech and Hearing Clinic at the University of Kansas.

On Other Fronts

Through the translation program of the American Institute of Physics and the cooperation of the National Science Foundation, complete English versions of 8 of the leading Soviet physics journals are available within 7 months after their publication in the U.S.S.R. One, *Soviet Physics–Acoustics*, is a translation of the *Journal of Acoustics* of the USSR Academy of Sciences. Although physical acoustics receive principal attention, "electro," "bio," and "psycho" acoustics are included, and pure research is emphasized. Another, *Soviet Physics – DOKLADY*, a translation of the Physics Section of the USSR Academy of Sciences, is described as an "all science journal."

The American Association for Cleft Palate Rehabilitation is planning to reprint back issues of the *Cleft Palate Newsletter and Bulletin*, Vols. 1-6, 1951-56. These issues will be reprinted and bound into a single paper-bound book. Cost will be determined by the number of books printed. Further information is available from E. H. Hixon, Editor, Department of Orthodontics, College of Dentistry, S.U.I., Iowa City, Iowa.

The *Journal of the American Dental Association* called attention to the publication, *Evolution of the Speech Apparatus*, by E. Lloyd DuBrue, DDS, Ph.D., Publication number 328, American Literature Series, Charles C. Thomas, Springfield, Illinois, 1958.

The August 22, 1959 issue of the *Journal of the American Medical Association* features a guest editorial, "Problems of Impaired Speech and Language" written by Wendell Johnson, Ph.D., Editor, ASHA.

Personals

Olive A. Whildin, Ph.D., Supervisor of Special Education of the Baltimore, Maryland Public Schools, retired on September 1, 1959. Dr. Whildin, who served with the department for more than thirty-four years, is an author of *The Newer Method in Speech Reading for the Hard of Hearing Child*.

A visitor to the editorial office of the *Journal of Speech and Hearing Disorders* on October 9 was Waldo Coleman, of San Francisco, who is well-known for his pioneering support of speech correction audiology and research. The 1959-1960 recipient of his grant for a secretary-to-the-editor of the *Journal* is Richard Tolman, M.A., speech pathology major. The editor, Mary Huber, Ph.D., reports that the *Journal* staff has moved to a more spacious office in the Fine Arts Building of Los Angeles State College.

Staff Appointments Announced

Dr. Merle E. Frampton, Director of the Special Education and Rehabilitation Study of the Subcommittee on Special Education of the U. S. House of Representatives Committee on Education and Labor, recently announced the following staff appointments: Robert Gates, Ph.D., Assistant Director; Elena D. Gall, Ph.D., Assistant to the Director, in Charge of Field Studies; Alice B. Hartman, Assistant to the Director and Legal Counsel; Augustine Regis Kelley, Assistant to the Director and Special Legislative Consultant.

Dr. Gates received his undergraduate training and doctoral degree in education at Syracuse University, New York. Long active in the field of special education, his previous experience in this area includes appointments of Coordinator of Special Educational Services of Hillsborough County, Florida; Consultant to the Florida State Department of Education on Education for Exceptional Children; Coordinator of the National Defense Act for the Florida State Department of Education; and Chairman of the Governor's Task Force on Cape Canaveral.

Dr. Gall is Assistant Professor of Education and Coordinator of Special Education at Hunter College, New York City. She received her doctoral degree in education from Teachers College, Columbia University, and has had many years of teaching experience in special education. The Co-editor of the three-volume reference work "Special Education for the Exceptional," Dr. Gall has served as Educational Consultant to the U. S. Department of Health, Education, and Welfare, and as Chairman of the School Service Committee of the Community Council of the City of New York.

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The magic of a music box . . . a little boy's laughter of delight.

Every endeavor offers some measure of satisfaction: a job well done, a profit made, a problem overcome. But in our profession there is a deeper, more enduring satisfaction: the sudden, youthful smile of an old man talking on the phone again . . . the young monther's sigh of contentment as she hears her child's soft "Good night" . . . this tot's awakening to the wonderful world of sound.

At times like these, you realize once again that to the hard-of-hearing a hearing aid is truly a dream come true, a miracle, a Christmas morning, and that to play some part in making these dreams come true is indeed a heart-warming and rewarding job.

To all our distributors and friends and to the hard-of-hearing everywhere. Audivox sends the season's happiest wishes. May all your dreams come true, and may your Christmas morning last all year.

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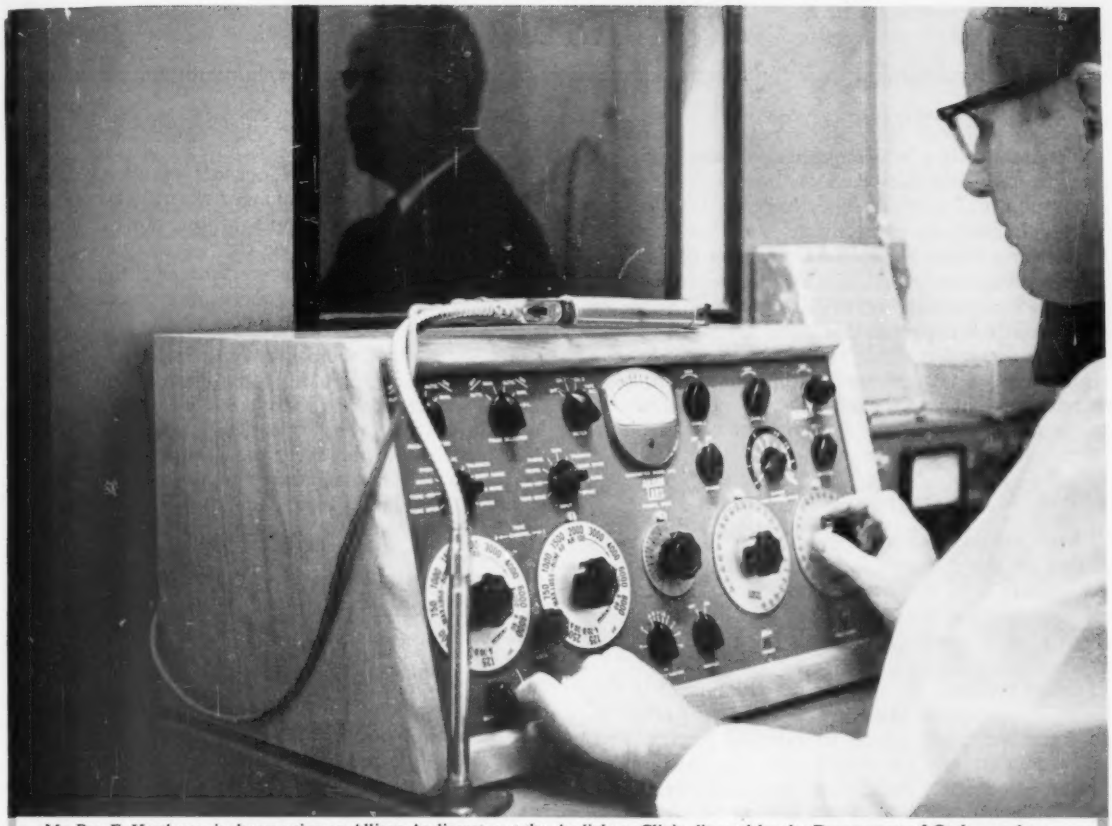


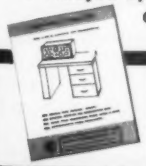
Mr. Roy E. Hartbauer is shown using an Allison Audiometer at the Audiology Clinic directed by the Department of Otolaryngology, School of Medicine, College of Medical Evangelists, at the White Memorial Hospital, Los Angeles, California.

Nothing Compares with The Allison Audiometer

Allison Series 21 Audiometers are the industry standard for large clinical audiometers. Allison 21 Audiometers are two-channel systems designed for two room installation. Each channel has inputs for microphone, phonograph, tone-air, white noise, complex noise, tape, talkback, and spare. (Channel one has a tone-bone position for bone conduction measurements; channel two has a tone sound field position for warble tone sound field audiograms.) Each channel has an attentuator covering a range from 100 db to −10 db, and oscillators with eleven discrete frequencies available: 125, 250, 500, 750, 1000, 1500, 2000, 3000, 4000, 6000, and 8000 cycles per second.

FEATURES OF THE ALLISON SERIES 21 AUDIOMETERS

- **Warble tone threshold through the loud-speaker**
- **Sound field pulsed white noise threshold**
- **Delayed speech malingering test, monaurally or binaurally**
- **Subjective evaluation of binaural hearing aids with speech in one loud-speaker, noise in another**
- **Filtered speech tests**
- **Prices start at $3,775.00**



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Forum

THANK YOU!

Numerous letters of congratulations on the first issues of *Asha* have been received, and it is not possible to publish all of these. They have been written by individual members, representatives of State Speech and Hearing Associations, and a growing community of *Asha* advertisers. *FORUM* takes this opportunity of gratefully acknowledging these significant votes of confidence. It is apparent that *Asha* has taken its first sure steps toward meeting an important need of the membership: a vital means of communication. May we reiterate that your comments and suggestions for the increased growth and development of this publication will indeed be welcome.

AS MINNESOTA GOES

I have just received my copy of *Asha*, the new publication of the Association. Congratulations on this new milestone in our Association's growth. This is a welcome addition to our other two excellent quarterly journals. Members of the Association can well be proud of our publications.

Further evidence of the growth and influence of the American Speech and Hearing Association is noted in the trend of many states to establish certification standards that are consistent with the Association clinical certification standards. As a member of the Speech Correction Advisory Committee for Minnesota I am happy to note that this committee has so recommended.

Again, congratulations to ASHA for *Asha*.

Martin Tonn, Coordinator
Special Education
State College
Moorhead, Minnesota

HEAR! HEAR!

An unattenuated "hear, hear" to Dr. Davis and his plea for an international audiometric zero! Aside from the obvious and strong arguments in favor of standardization for the sake of comparability, there has long existed a need for the adoption of a more realistic standard of normalcy than the present American Standard.

Perhaps the most unfortunate consequence of the well-known discrepancy between average normal threshold and American Standard audiometric zero lies in the resulting difficulties of *maintaining* the calibration of an audiometer.

Most audiometer users do not find it practical to maintain an artificial ear for periodic calibration checks. Consequently, the vast majority must either rely on "real ear" calibration techniques, or in shipping the instrument back to the factory for recalibration.

The "real ear" method consists of averaging the threshold responses of a number of subjects constituting a representative sample of the normal hearing population, and determining the necessary corrections from the difference between zero and the average threshold readings. This procedure is recommended by a number of leading audiologists.

However, since there is no practical way of selecting a sample comparable to the large, biased sample of the historic Public Health Survey, about the only alternative is to use a sample of truly normal ears. This results in a relatively realistic calibration which is not, however, comparable to the original factory calibration. Thus, every clinic, school or physician using this method is, in effect, making up his own standard. The adoption of a realistic international standard will make zero not only more meaningful, but more reproducible as well.

The disadvantages of factory recalibration are well known. The instrument is subjected to many potentially damaging insults in transit and may be out of calibration again before it is put back into use. The procedure is costly in time and money. Bone conduction calibration means little since each manufacturer sets his own standards for this. As a result, a great many audiometers are simply not calibrated often enough or, in some cases, never.

When a new and realistic standard is adopted, it will be possible for nearly every audiometer user to check calibration error by the "real ear" method. For the benefit of those who are not satisfied to use a correction table, I would like to suggest that manufacturers provide their audiometers with variable trimmer resistors so that needed output level adjustments at the several frequencies can be made locally with a screwdriver and a voltmeter.

Let us follow the lead of Dr. Davis and give vocal support to this cause individually and as an organization.

Otto J. Menzel, Director
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PLEA FOR TERMINOLOGY

Congratulations on the publication *Asha*. It fills a very real need in the lives of all of us concerned with the inadequacies of speech and hearing. I shall use it with my senior and graduate students to help them realize the scope and significance of our National Association.

You asked for comments and suggestions. I should like especially to see a follow-up of Stanley Ainsworth's *Plea for Terminology* which is explicit. We are using many terms which are open to misinterpretation, and are inaccurate as well as inadequate. There is little doubt but that the terms *correction* or *correctionist* are misleading when applied to the individual working in the field of speech and hearing disorders. For example, one does not correct stuttering, delayed speech, hearing impairment. The terms are inexact.

On the other hand, I must take issue with the statement in the article that "a therapist is a technician who must be under a medical supervisor." The term *therapy* means treatment. Dorland's *American Medical Dictionary* defines it as "the management and care of a patient for the purpose of combating disease or disorder." The implication is, of course, that this be done by a qualified person but not necessarily a medical specialist, even though there is no one in speech and hearing therapy who would not welcome advice and assistance from a qualified member of the medical profession. The term *therapeutics*—"that part of the medical profession which treats of the application of remedies for disease"—is more specifically related to medicine than the term *therapy* unless one speaks of medical therapy.

May I also call attention to our use of such descriptive terms as a *speech-defective child* which should be anathema to anyone working with parents of children, especially when there is no suggestion of lack of imperfection of some structure. Parents resent the idea their children are defective, and overlook the qualifying term *speech*. There is also careless use of the term *case* when referring to human beings. The Medical Dictionary even goes so far as to say that "A case is not synonymous with a patient, for the latter is the human being affected with the disease." For example, why not *child study* or *personality* study instead of case study? There is further argument concerning our use of *diagnosis* instead of *appraisal*, vocal *cords* instead of vocal folds or bands.

I am not writing an article, merely applauding Stanley Ainsworth's suggestions and re-emphasizing the need for explicit terminology and usage.

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PUBLICATION NOTE:

Please indicate approval of publication for your letter or specific parts thereof when submitting material to *FORUM*. Contributions to *FORUM* should be addressed to *Walter W. Amster*, Rehabilitation Center For Crippled Children and Adults, 1475 N.W. 14th Avenue, Miami, Florida.

ASHA — PURDUE UNIVERSITY STUDY

Full scale efforts are now being launched in the ASHA-U. S. Office of Education-Purdue University National Study in Public School Speech and Hearing Services. Appointments to the 9 work groups have been made and some slight re-alignment of personnel has brought all the groups to full strength, as authorized by the Office of Education contract. However, according to Project Director M. D. Steer, most of the work groups are in process of setting up subgroups to carry out designated parts of the total task.

Dr. Steer has been gratified to receive many offers from ASHA members to participate in the project. "There are many important subgroup positions to be filled," he states, "and we are referring these volunteers to appropriate work groups." Prospective volunteers are encouraged to review the list of groups below and to write to Dr. Steer (at the Speech and Hearing Clinic, Purdue University, Lafayette, Indiana), noting, in order of preference, at least three groups on which they would be interested in working.

I. Clinical Practice: Remedial Procedures
(therapeutic and re-education techniques; training materials–games, books, records, etc.)

II. Clinical Practice: Diagnosis and Measurement
(techniques and instruments for testing and periodic evaluation; criteria for admission to and dismissal from therapy)

III. Program Management: Schedules, Reports, Budgets
(types of organization, recording and financing; salaries and allowances)

IV. Administration and Supervision
(practices in organizing, unifying and supervising programs; physical facilities and instrumentation)

V. Speech and Language
(developmental and speech improvement programs)

VI. Professional Standards: Training, Licensing and Certification
(local, state and national regulations and practices and their influence on training programs; practice teaching)

VII. Recruitment
(methods for increasing participation in the field; brochures)

VIII. Professional Definitions and Relationships
(areas of independence and cooperation among the various professions; standards of private practice)

IX. Research
(types, extent and frequency of experimentation in schools)

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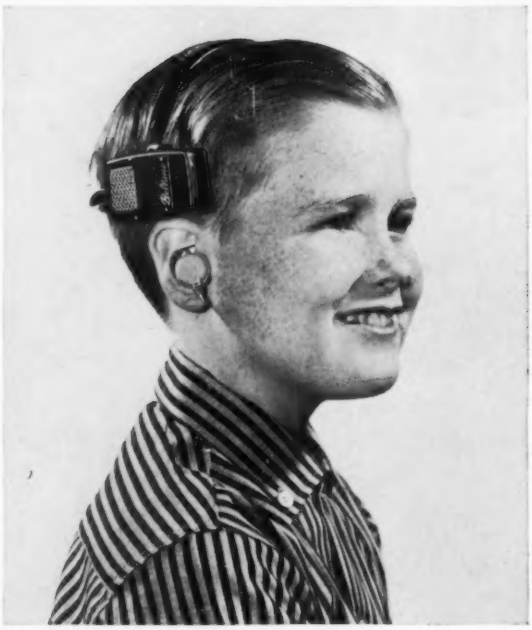

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